

1

INSTRUCTIONS

TO ATTEND PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10220

10232

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>		LENGTH OF STAY (In the place) <i>15 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>		TOWN <i>Bel Air</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>no</i>				STREET ADDRESS (If rural give location) <i>no</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>EMMA</i> (Middle) <i>FRANCES</i> (Last) <i>BEAN</i>				(Month) <i>10</i> (Day) <i>22</i> (Year) <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>5-30-1878</i>	9. AGE last Birthday <i>78</i> yrs.	IF UNDER 1 YEAR Months <i></i> Days <i></i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home Work</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Ignatius</i>			14. MOTHER'S MAIDEN NAME <i>NANIE THOMAS</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>MRS. MABEL ELDER Bel Air, Md.</i>		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A) <i>GENERAL VISCERAL FAILURE</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1954</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>GENERALIZED ARTERIO</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>SCLEROSIS</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5-4-19</i> to <i>10-22-56</i> , that I last saw the deceased alive on <i>10-24-56</i> , 19 <i>56</i> , and that death occurred at <i>11:30</i> M, from the causes and on the date stated above.							
SIGNATURE <i>M. Elder</i>				ADDRESS (Street, city, town, state) <i>La Plata, Md.</i>		DATE SIGNED <i>10-22-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>10-24-56</i>		NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>		LOCATION (City, town, or county) (State) <i>La Plata, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mrs. P. Willo Posey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Honolt Funeral Home</i>		ADDRESS <i>Bel Air, Md.</i>	
DATE <i>10/24/56</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10233

CERTIFICATE OF DEATH

Reg. Dist. No. 10221

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlotte Hall Rural		c. LENGTH OF STAY IN 1b 7 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Charlotte Hall Rural	
3. NAME OF DECEASED (Type or print) ZANIS ARVIDO BLANKFELDS		4. DATE OF DEATH Month 10 Day 29 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? Latvia ✓	
13. FATHER'S NAME Karliz Blankfelds		14. MOTHER'S MAIDEN NAME ANNETTE Jirgensons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Karliz Blankfelds		Address Charlotte Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic cardiovascular disease unknown DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 12 , 19 56 , to Oct 29 , 19 56 , that I last saw the deceased alive on Oct 29 , 19 56 , and that death occurred at 6:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mechanicville Md DATE SIGNED 10/30/56 ACTUAL SIGNATURE J. Roy Gwyther M.D. PHYSICIAN'S NAME (Type) J. Roy Gwyther			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-1-56	
22c. NAME OF CEMETERY OR CREMATORY St Paul's Cem.		22d. LOCATION (City, town, or county) (State) Charlotte Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home		ADDRESS Waldorf, Md.	
24a. REC'D BY REGISTRAR NOV 2 1956		24b. REGISTRAR'S SIGNATURE L. H. Hensch	

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
Home		Male		35		White		Teacher	
6. DATE OF DEATH		7. TIME OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF BURIAL	
Nov 1, 1956		10:00 AM		Heart Disease		Natural		Catholic Cemetery	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF MINISTER		15. SIGNATURE OF CORONER	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF CLERK		18. SIGNATURE OF CHIEF CLERK		19. SIGNATURE OF ASSISTANT CLERK		20. SIGNATURE OF DEPUTY CLERK	

RECEIVED
NOV 2 1956
BUREAU V. S.

10234 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10222

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burke</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Russell</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>ANDREW</u> Middle <u>BURROUGHS</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 25, 1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm A. BURROUGHS</u>		14. MOTHER'S MAIDEN NAME <u>Lottie W Jarboe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>677-20-7994</u>	
17. INFORMANT <u>LaPlata Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension & Cor Bovis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-28-56</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> to <u>10-28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-26</u> , 19 <u>56</u> , and that death occurred at <u>6:15</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. J. Fedelen</u> M.D.		DATE SIGNED <u>10-28-56</u>	
PHYSICIAN'S NAME (Type) <u>E. J. FEDELEN M.D.</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Oct 31, 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wickhart Inc LaPlata Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>10/29/56</u>		24b. REGISTRAR'S SIGNATURE <u>Julius H. Basey</u>	

BUREAU V. S.

OCT 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10223

10235

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Archie First Butler Middle Butler Last				4. DATE OF DEATH Month October Day 16 Year 1956			
5. SEX Male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1901 34		9. AGE (In years last birthday) yrs. 54		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Bolt Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Francis Butler				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-16-7207		17. INFORMANT Hurd Laplata Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 10-6-56 Gradual	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-9-56 , 19 56 , to 10-16-56 , 19 56 , that I last saw the deceased alive on 10-16-56 , 19 56 , and that death occurred at 2:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William J. Kurz M.D.				ADDRESS (Street, city or town, state) La Plata Md DATE SIGNED 10/16/56			
PHYSICIAN'S NAME (Type) William J. Kurz, M.D.				La Plata, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		10/20/56		Sacred Heart		La Plata Md	
23. FUNERAL DIRECTOR'S SIGNATURE Crehart Inc ADDRESS La Plata				24a. REC'D BY REGISTRAR 10/22/56		24b. REGISTRAR'S SIGNATURE Julia H. Carey	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be relayed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. If the funeral director is not available, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6205 10-16-56 et

CERTIFICATE OF DEATH

10224

Reg. Dist. No.

10236

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> <u>Nanjemoy</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaPlata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanjemoy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>GLADYS SNYDER</u> First Middle Last		4. DATE OF DEATH <u>Oct.</u> Month <u>5</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Approx. 49</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Gov</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph C Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Fellie Blayser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Theodore Davis</u> Address <u>Nanjemoy Md</u>	
17. INFORMANT <u>Theodore Davis</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>170x</u> DUE TO (b) <u>Adenocarcinoma (grov) of Left Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>± Nodal Metastases</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> <u>9 MOS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 2, 1956</u> , to <u>Oct. 5, 1956</u> , that I last saw the deceased alive on <u>Oct. 5, 1956</u> , and that death occurred at <u>1:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Parran Jarboe</u> M.D.		ADDRESS (Street, city or town, state) <u>La Plata, Md</u> DATE SIGNED <u>10-5-56</u>	
PHYSICIAN'S NAME (Type) <u>J. PARRAN JARBOE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10-8-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Nanjemoy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nanjemoy Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u> ADDRESS <u>Washington, Md</u>		24a. REC'D BY REGISTRAR <u>Oct 9 1956</u> 24b. REGISTRAR'S SIGNATURE <u>J. H. Pacey</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]		AGE [Faint, illegible text]	
DATE OF DEATH [Faint, illegible text]		PLACE OF DEATH [Faint, illegible text]		COUNTY [Faint, illegible text]	
TIME OF DEATH [Faint, illegible text]		CAUSE OF DEATH [Faint, illegible text]		MANNER OF DEATH [Faint, illegible text]	
PLACE OF BIRTH [Faint, illegible text]		DATE OF BIRTH [Faint, illegible text]		SEX [Faint, illegible text]	
OCCUPATION [Faint, illegible text]		EDUCATION [Faint, illegible text]		RELIGION [Faint, illegible text]	
MARITAL STATUS [Faint, illegible text]		PREVIOUS MARRIAGES [Faint, illegible text]		PREVIOUS DEATHS [Faint, illegible text]	
SIGNATURE OF DECEASED [Faint, illegible text]		SIGNATURE OF WITNESS [Faint, illegible text]		SIGNATURE OF PHYSICIAN [Faint, illegible text]	
SIGNATURE OF CLERK [Faint, illegible text]		SIGNATURE OF JUDGE [Faint, illegible text]		SIGNATURE OF SHERIFF [Faint, illegible text]	

BUREAU V. 2

OCT 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10225

10237

CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH o. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE			
c. LENGTH OF STAY IN 1b LIFE				d. STREET ADDRESS STATE ROUTE #5			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CECELIA BURCH FERRALL				4. DATE OF DEATH Month Day Year OCTOBER 30 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE-U.S.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 26, 1920	
9. AGE (In years last birthday) 36 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JOSEPH BENJAMIN BURCH		14. MOTHER'S MAIDEN NAME LUCY DENT CARRICO			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Address FRANCIS J. FERRALL; HUGHESVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OSTEOGENIC SARCOMA, RIGHT FEMUR 196X DUE TO (b) SARCOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS 5 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —		20h. (State) —	
21. I certify that I attended the deceased from APRIL 30, 1956 , to OCTOBER 30, 1956 , that I last saw the deceased alive on OCTOBER 29, 1956 , and that death occurred at 2:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Box 65, Hughesville, Md. DATE SIGNED 10/30/56 ACTUAL SIGNATURE John H. Griffin, M.D. PHYSICIAN'S NAME (Type) —							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 2, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Marys		22d. LOCATION (City, town, or county) (State) Bryantown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home				ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR DATE Nov. 5, 1956	
24b. REGISTRAR'S SIGNATURE Julia Posey							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10226

100

10238 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND CITY OR TOWN <u>Port Tobacco</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Penna</u> COUNTY <u>Blair</u> CITY OR TOWN <u>Altoona</u> STREET ADDRESS <u>2521 Broad Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Naomi Apple Hammond</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>22</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>5-17-1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>62</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Indiana Co Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY KING APPLE</u>		14. MOTHER'S MAIDEN NAME <u>LINNIE BURKET</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS <u>Catolyn GRAY</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 175X IMMEDIATE CAUSE (A) <u>Cancer of Ovary</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>c metastases</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>1951</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-7</u> , 19 <u>56</u> , to <u>10-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-14</u> , 19 <u>56</u> , and that death occurred at <u>9A</u> M., from the causes and on the date stated above.			
SIGNATURE <u>E. Hedelen</u>		DATE SIGNED <u>10-12-56</u>	
M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. DATE THEREOF <u>10-25-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Fairview Cem.</u>		LOCATION (City, town, or county) (State) <u>Altoona Penn.</u>	
25. REC'D BY REGISTRAR <u>OCT 24 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Spott Funeral Home</u>	
REGISTRAR'S SIGNATURE <u>Julia Tracy</u>		ADDRESS <u>Ward...</u>	

CERTIFICATE OF DEATH

Part One - For Use by the Physician

1. Name of deceased (Print or write full name)

2. Date of death (Month, day, year)

3. Place of death (Street, city, state, and zip)

4. Cause of death (Immediate cause)

5. Cause of death (Underlying cause)

6. Cause of death (Contributing cause)

7. Manner of death (Natural, accident, homicide, suicide, undetermined)

8. Signature of physician (Print name and sign)

9. Signature of physician (Print name and sign)

10. Signature of physician (Print name and sign)

11. Signature of physician (Print name and sign)

12. Signature of physician (Print name and sign)

13. Signature of physician (Print name and sign)

14. Signature of physician (Print name and sign)

15. Signature of physician (Print name and sign)

16. Signature of physician (Print name and sign)

17. Signature of physician (Print name and sign)

18. Signature of physician (Print name and sign)

19. Signature of physician (Print name and sign)

20. Signature of physician (Print name and sign)

21. Signature of physician (Print name and sign)

22. Signature of physician (Print name and sign)

23. Signature of physician (Print name and sign)

24. Signature of physician (Print name and sign)

25. Signature of physician (Print name and sign)

26. Signature of physician (Print name and sign)

27. Signature of physician (Print name and sign)

28. Signature of physician (Print name and sign)

29. Signature of physician (Print name and sign)

30. Signature of physician (Print name and sign)

31. Signature of physician (Print name and sign)

32. Signature of physician (Print name and sign)

33. Signature of physician (Print name and sign)

34. Signature of physician (Print name and sign)

35. Signature of physician (Print name and sign)

36. Signature of physician (Print name and sign)

37. Signature of physician (Print name and sign)

38. Signature of physician (Print name and sign)

39. Signature of physician (Print name and sign)

40. Signature of physician (Print name and sign)

41. Signature of physician (Print name and sign)

42. Signature of physician (Print name and sign)

43. Signature of physician (Print name and sign)

BUREAU V. S.

OCT 24 1956

RECEIVED

10-22-56

SMOOTH CUTTING

10239

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dentonville</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dentonville</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>Philip</i> Middle <i>-</i> Last <i>LEE</i>				4. DATE OF DEATH Month <i>Oct</i> Day <i>8</i> Year <i>1956</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>about 80 yrs.</i>		9. AGE (In years last birthday)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>baron</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>laborer</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John Lee</i>				14. MOTHER'S MAIDEN NAME <i>Unk.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mary Lee Dentonville Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Choked - vascular accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>10-8-56</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. J. EDELEN</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Oct 4, 1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Union Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Waldorf Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The HUNTT Funeral Home</i>				24a. REC'D BY REGISTRAR <i>DATE 15 1956</i>			
				24b. REGISTRAR'S SIGNATURE <i>Mrs. F. H. B. Pacey</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. Your file should be labeled "FURNERAL DIRECTOR". FOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATEMENT OF HEALTH - BELLHORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. BELLHORE		45		M		W		10/15/1956		BELLHORE, N.Y.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF EXAMINATION		PLACE OF EXAMINATION	
BELLHORE, N.Y.		FARMER		HEART DISEASE		NATURAL		10/15/1956		BELLHORE, N.Y.	
PREVIOUS ILLNESS		HISTORY OF PRESENT ILLNESS		SYMPTOMS		SIGNS		TESTS		TREATMENT	
NONE		Sudden onset of chest pain, radiating to left arm and jaw, associated with sweating and nausea.		Chest pain, shortness of breath, sweating, nausea.		Tachycardia, hypertension, clear lungs.		ECG, chest X-ray, blood tests.		Nitroglycerin, aspirin, morphine.	
FAMILY HISTORY		SOCIAL HISTORY		EDUCATION		RELIGION		MARRIAGE		CHILDREN	
None known.		None known.		High School		Roman Catholic		Married		3	
SIGNED AND SWORN TO before me this 15th day of October, 1956, at Bellhore, New York.		SUBSCRIBED and sworn to before me this 15th day of October, 1956, at Bellhore, New York.		NOTARY PUBLIC		JURY		JURY		JURY	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

OCT 15 1956

RECEIVED

VS A15C 1-55 10M

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>La Plata</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians' Memorial Hosp. La Plata, Maryland</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Grayton, Maryland</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print) <u>James R. Lynch</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10- 17 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 4, 1908</u>
9. AGE last birthday <u>48</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.) _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Charles Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John B. Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Ella F Smoot</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-14-3528</u>	
17. INFORMANT & ADDRESS <u>Edna Foster La Plata Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH (A) IMMEDIATE CAUSE <u>241X Congestive Heart Failure</u>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>10-14-56</u>	
(B) ANTECEDENT CAUSE(S) DUE TO <u>Bronchial Asthma</u>		<u>1950</u>	
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____		_____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		_____	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		_____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19<u>56</u>, to _____, 19____, that I last saw the deceased alive on <u>10-17</u>, 19<u>56</u>, and that death occurred at _____ M, from the causes and on the date stated above. SIGNATURE <u>E. Odelen</u> ADDRESS (Street, city, town, state) <u>La Plata Md</u> DATE SIGNED <u>10-18-56</u> M.D. _____			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/20/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Hill top</u>		LOCATION (City, town, or county) <u>Hill top Md</u>	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Julia H. Pacey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Prehart Inc. La Plata Md</u>	
DATE <u>10/22/56</u>		ADDRESS _____	

CERTIFICATE OF DEATH

1. PLACE OF DEATH

2. NAME OF DECEASED
 3. SEX
 4. AGE
 5. DATE OF BIRTH
 6. PLACE OF BIRTH

7. OCCUPATION
 8. MARITAL STATUS
 9. COLOR

10. CAUSE OF DEATH
 11. MANNER OF DEATH

12. TIME OF DEATH
 13. PLACE OF DEATH

14. SIGNATURE OF PHYSICIAN
 15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF WITNESSES
 17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED
 19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED
 21. SIGNATURE OF DECEASED

22. SIGNATURE OF DECEASED
 23. SIGNATURE OF DECEASED

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38. SIGNATURE OF DECEASED
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40. SIGNATURE OF DECEASED
 41. SIGNATURE OF DECEASED

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

BUREAU V. S.

NOV 24 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10229

Reg. Dist. No. 100

10241

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LA PLATA</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>MARBURY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Reuben Austin MADDOX</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 27 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6 May 1887</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Gmt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Powder Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY CLAY MADDOX</u>				14. MOTHER'S MAIDEN NAME <u>M. Posey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>Russell A. Maddox - Lexington</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Respiratory Collapse</u>						<u>12 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral vascular accident</u>						<u>6 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>21 Oct</u> , 19 <u>56</u> , to <u>27 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>27 Oct</u> , 19 <u>56</u> , and that death occurred at <u>12:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>J. Wooddy</u>		M.D. <u>Sanwood Clinic LaPlata Md</u>		DATE SIGNED <u>27 Oct 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-30-56</u>		NAME OF CEMETERY OR CREMATORY <u>Marbury Baptist Cem.</u>		LOCATION (City, town, or county) (State) <u>Marbury, Md.</u>	
24. REC'D BY REGISTRAR <u>NOV-1-1956</u>		REGISTRAR'S SIGNATURE <u>Gulcia Propp</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF BIRTH

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. RACE

14. BIRTH DATE

15. BIRTH PLACE

16. BIRTH TIME

17. BIRTH WEIGHT

18. BIRTH LENGTH

19. BIRTH HEAD CIRCUMFERENCE

20. BIRTH SKIN COLOR

21. BIRTH HAIR COLOR

22. BIRTH EYE COLOR

23. BIRTH MOUTH COLOR

24. BIRTH NOSE COLOR

25. BIRTH EAR COLOR

26. BIRTH FINGER COLOR

27. BIRTH TOE COLOR

28. BIRTH NAIL COLOR

29. BIRTH SKIN CONDITION

30. BIRTH SKIN DISEASES

31. BIRTH SKIN LESIONS

32. BIRTH SKIN TREATMENT

33. BIRTH SKIN HISTORY

34. BIRTH SKIN EXAMINATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10230

CERTIFICATE OF DEATH

Reg. Dist. No. 101

10242

1. PLACE OF DEATH a. COUNTY <u>La Plata Md.</u> <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata Md</u> c. LENGTH OF STAY IN 1b <u>15-Hours</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hospital La Plata Md</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>'Baby' Manning</u> First Middle Last			4. DATE OF DEATH <u>10-21-56</u> Month Day Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-56</u>		9. AGE (In years last birthday) yrs. <u>15</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>US.</u>			13. FATHER'S NAME <u>Anthony Howard Manning</u>				
14. MOTHER'S MAIDEN NAME <u>Ethelery Am Marie Swann</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u> <u>No</u>				
16. SOCIAL SECURITY NO. <u>N one</u>			17. INFORMANT <u>Mother- Ethelery Manning</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>774X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity- Five months Gestation</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>10-20-56</u> , 19 <u> </u> , to <u>10-21-56</u> , 19 <u> </u> , that I last saw the deceased alive on <u>10-21-56</u> , 19 <u> </u> , and that death occurred at <u>4:20A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Indian Head Md.</u> DATE SIGNED <u>10-21-56</u> ACTUAL SIGNATURE <u>James E. Andrews</u> M.D. PHYSICIAN'S NAME (Type) <u>James E. Andrews</u> <u>Indian Head Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 24 '56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>			
22d. LOCATION (City, town, or county) (State) <u>Glymont Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson + Jenkins - 1702-12th</u> ADDRESS <u>2066182XV2</u>					
24a. REC'D BY REGISTRAR DATE <u>10/23/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Swann</u>					

BUREAU V.

OCT 30 1956

RECEIVED

.10243

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

106

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>office Dr. F.A. Susan</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ripley (RFD La Plata)</u>	
3. NAME OF DECEASED (Type or print) First <u>Lomax</u> Middle <u>Byron</u> Last <u>Rhodes</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9, 1901</u>
9. AGE (In years) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Quartermaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Powder factory)</u>	
11. BIRTHPLACE (State or foreign country) <u>Highland Home, Ala</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Clude Rhodes</u>		14. MOTHER'S MAIDEN NAME <u>Eunice Pace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>1920-28</u>	
17. INFORMANT <u>Mrs L.B. Rhodes, RFD La Plata Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank A. Susan</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank A. Susan M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-10-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Heath Funeral Home</u>		ADDRESS <u>Wildcat Rd.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Odey Price</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. If the registrant permits, the registrant permit to burial, cremation, or removal.

100 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

OCT 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be returned by the hospital or attending physician.
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10244
CERTIFICATE OF DEATH

10233

Reg. Dist. No.

105

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Md. b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) James First Wallace Middle Robey Last		4. DATE OF DEATH Month Oct. Day 24 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 -17- 1891
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Millard Robey		14. MOTHER'S MAIDEN NAME Addie Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214 36 3606	
17. INFORMANT Mrs Ola Robey		Address White Plains, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 8-55	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-55 , 19 55 , to 10-24-56 , that I last saw the deceased alive on 10-23-56 , and that death occurred at 2 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10-15-56			
ACTUAL SIGNATURE E. J. EDELEN M.D.		DATE SIGNED 10-15-56	
PHYSICIAN'S NAME (Type) E. J. EDELEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-26-56	
22c. NAME OF CEMETERY OR CREMATORY St Paul's Cem.		22d. LOCATION (City, town, or county) (State) Waldorf, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home ADDRESS Waldorf, Md.		24a. REC'D BY REGISTRAR ACT 29 1956	
24b. REGISTRAR'S SIGNATURE M. L. Morley			

tem 18, Film G206

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10245

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Md. b. COUNTY St Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata			c. LENGTH OF STAY IN 1b unk.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville (Rural) 18X-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elmer Middle Thomas Last Thomas				4. DATE OF DEATH Month October Day 1 Year 19 56			
5. SEX M.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 24, 1923		9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months 33 Days 33 Hours 33 Min.	IF UNDER 24 HRS. Hours 33 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Unk.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer Thomas, Sr.				14. MOTHER'S MAIDEN NAME Carrie C. Chase			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213 16 2792		17. INFORMANT Physicians Memorial Hosp. La Plata, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William J. Goudy M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 5, 1956		22c. NAME OF CEMETERY OR CREMATORY St Mary's Cem.		22d. LOCATION (City, town, or county) (State) Bryantown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home Waldorf, Md.				24a. REC'D BY REGISTRAR OCT 8, 1956		24b. REGISTRAR'S SIGNATURE F. H. Poole	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical examiner in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained by your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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may be removed by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10245 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10245 CERTIFICATE OF DEATH

10235

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gallant Green</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles</u> <u>Gallant Green</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Joseph</u> <u>Infant</u> <u>Leroy</u> <u>THOMPSON</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11 1956</u>	9. AGE (In years last birthday) <u>1 day</u>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ismin Edward Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Theresa Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edward Thompson</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>773.5</u> <u>respiratory failure</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>24 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 12, 1956</u> , to <u>only</u> , 19 <u>1956</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. M. Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>La Plata Md</u> DATE SIGNED <u>10/12/56</u>			
PHYSICIAN'S NAME (Type) <u>F. M. JOHNSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 13 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens</u>		22d. LOCATION (City, town, or county) (State) <u>Charles Point Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Funeral Home Inc.</u>				24a. REC'D BY REGISTRAR <u>Oct 13</u>		24b. REGISTRAR'S SIGNATURE <u>Julia Posey</u>	

Two for One: FilmG206 11-14-56 et

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Chas. M. Felt

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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